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March 9, 2008

Mail Stop Amendment
Commissioner for Patents
U.S. Patent and Trademark Office
Attn: Gabrielle McCormick
Patent Examiner, Art Unit 3629
P.O. Box 1450
Alexandria, VA 22313-1450

Dear Ms. McCormick:

This responds to your Office Action Summary regarding my application regarding an “Automated Issue-Communication Method that Significantly Improves an Organization’s Safety Culture and Corporate Forthrightness by Encouraging the Communication of Issues and Concerns, Circumventing Middle-Management Filters while Suppressing ‘Whistleblower’ Creation.”

First, I would like to say that when I received this Office Action Summary, it appeared based on the language that you used that a prior patent application had accomplished the same intended utility as in my application, so I set it aside rather than investigate all the details. I was also impressed by the trouble you went to in explaining the shortcomings in my application, as I obviously am not proficient in filing patents.

Since setting it aside as already patented, I have been reassigned by my company to supervise 39 classified nuclear weapons document reviewers. One of my reviewers is assigned to review patent applications potentially involving nuclear weapon technology, which indicates that the Patent Office does not have a capability to do this in-house. It occurred to me that perhaps the same might be true for matters like nuclear industry safety culture, since I am probably one of a handful of nuclear engineers who really understand that area, as well.

So I picked up the Office Action Summary that you sent and read more carefully, including the somewhat extensive previous patent application (Carlson, et al; US-2003/0135378). The incident reporting system described in this previous application does not really address “safety culture” at all, despite your statement that it does. Nor

does it address “peer reviews” at all, despite your statement that it does. Consequently, I can only conclude that, based on your experience and knowledge, you inferred that this prior patent application addressed these issues, making my patent idea of no new utility. This is an incorrect conclusion on your part, but it is not clear to me how to overcome your objections other than to appear argumentative over something that you seem to be so sure about. I can point to some references on my nuclear safety culture web page that will be of some help, and I provide the following discussion to help you understand the utility of this new utility patent as already described in my original application.

First, I should point out that the previous art by Carlson, while impressive in managing the various aspects of processing incident reports, is not really different than what I have seen already in place in many nuclear power plants in the US, which have very similar computer systems in place (with similar methods) to manage their “corrective action” programs. Similar systems have been in use at National Laboratories and in the Navy, all based on my own experience. I really doubt the validity of such a patent that merely implements common sense, but this is not my basic point.

My point is that I have seen systems such as Carlson’s before as I have since 1986 performed inspections at 14 different commercial nuclear power plants and at several National Laboratories and Department of Energy nuclear weapon production facilities. Reporting and corrective action programs as described by Carlson are the rule and not the exception, and I have seen some that are more sophisticated. My point is that, even with such a sophisticated computer system in place to deal with issues, corrective actions, and incident reports (pretty much all done on one system), they still have significant “safety culture” problems. Also, none of them have the kind of “peer review” method that I propose, to include Carlson. Moreover, failure to have an effective “safety culture” can cost a nuclear utility (and also any other large industrial company) hundreds of millions of dollars due to regulatory injunctions or shutdowns.

For example, only a few years ago the Davis-Besse Nuclear Plant was shut down for about 2 years, losing hundreds of thousands of dollars each day because their lack or an adequate safety culture caused the reactor to be started up without completing a key inspection of their control rod drive mechanism nozzles, which were later found to have corrosion and erosion problems that made the reactor coolant system unsafe for operation due to the possibility of a major rupture. Other major and expensive accidents occurred at Chernobyl in the Ukraine and at Three Mile Island in Pennsylvania. I dare say all such plants had excellent incident report management systems in place, computer based and otherwise, but they did not have a good safety culture, much less a good nuclear safety culture.

As for whistleblowers, the Nuclear Regulatory Commission itself is not impressed with such things as incident report management systems (actually a subset of corrective action systems) to create a good safety culture (they call it a “safety conscious work place”) since they also have a program wherein the workers are encouraged to bypass the plant

management and send their complaints on nuclear safety directly to the NRC regulators. They have forms posted in the hallways at the different plants to encourage workers to essentially report on their management's failure to support a good safety culture.

The first real whistleblower I encountered was James Stone, an employee at the Energy Department's Rocky Flats Plant in Colorado. I was the coordinator for the investigation team of 13 nationally known experts who were asked to investigate Mr. Stone's safety allegations at the plant, in parallel with other safety allegations raised by local citizens and by the Federal Bureau of Investigation. Mr. Stone (a plant engineer) had raised questions about possible plutonium contamination in the ductwork of the plutonium buildings based on his similar experience with beryllium in the beryllium building. Workers had routinely put screwdrivers through their glovebox filters to keep from losing vacuum and having to shutdown their glovebox line. Machining of plutonium metal in the glovebox would result in plutonium dust getting past the filters and into the ventilation system ductwork. Responding properly to his safety concerns would have caused the production of nuclear weapon pits (sometimes called triggers by the news media) to stop while the issue was investigated.

The plant and DOE managers refused to stop work, and they simply fired Mr. Stone as a troublemaker, but he turned out to be a whistleblower in that he was proven (by me and my team) to be absolutely correct. The plutonium building ductwork was shown to be contaminated with plutonium dust to the point that the radiation levels in the working areas were going up significantly. Had the issue not been looked into, a criticality might have eventually occurred in the ductwork. The only reason that the problem was finally validated and resolved was due to public pressure and the raid on the plant by the FBI in the summer of 1989.

So, James Stone was vindicated, but as a whistleblower who was proven to be right, he was still not reinstated, acknowledged, or given back pay, even though I personally recommended all of these things to DOE attorneys. Once a whistleblower, the managers and their attorneys often do not do the right thing, regardless of who is right. Thus, it is cases like this that cause plant workers to keep their concerns to themselves, making the rest of us less safe.

As for using an "incident report" as a safety culture benefit, I point out that at the Rocky Flats Plant they already had such an incident report from the beryllium building that should have alerted them to the same conditions in the plutonium building. Such facts simply do not get proper attention and are often suppressed by middle managers, who are often under pressure to meet production goals. Moreover, it only takes one middle manager to say "No" to an issue to stop action while it takes all of them to say "Yes" to make something happen. The production of an "incident report" by those involved (a typical process) does not necessarily involve a peer review or peer comments. Indeed, by the time there is an "incident" to report on, the safety culture has already failed!

A good safety culture is supported in the current scope of utility that I propose because it reduces the probability of an incident occurring in the first place, which is indeed the goal of the regulators. It would have been much better both financially but also in terms of safety if the safety cultures at Three Mile Island, Chernobyl, and Davis Besse had the benefit of the kind of safety culture enhancing method and modest computer-related system that I propose. My patent application's utility is in producing a shield of anonymity as well as the support of peer commentary or just simple agreement (or disagreement) with the position of the worker initiating the report of a safety issue or other related concern.

The above discussion may be easily enhanced by learning more about my views and experience on safety culture, which is predominantly a concept that gets strong support in the nuclear industry and in the chemical/petroleum industries. My additional views on such things have been on my web site for almost 10 years now.

They are either on or linked to my "Nuclear Safety Culture" page at
<http://technidigm.org/technuke/nuclear.htm>. Links include:

My presentation to the summer meeting of the American Nuclear Society on the Navy approach to nuclear safety culture (June 2, 2003) is at:
http://technidigm.org/technuke/assess/Jones%20ANS%20NSC%20Presentation_files/frame.htm

An examination on basic safety culture principles for more experienced nuclear industry workers at <http://technidigm.org/technuke/nsctests/checkin.htm>.

A simple embodiment of my method (proposed patent) is also on my website, at
<http://technidigm.org/issues/issuereport.htm>, where anyone can go to submit an issue anonymously. It is not incorporated as part of my patent submittal because it is not considered necessary to understand its utility and functionality.

I am not aware of anyone else who has gone to the trouble of putting this much information on this topic on the Internet. Given the additional fact that I have been in the nuclear industry for over 40 years, I think I can claim to understand safety culture in its finest form, which makes me a subject matter expert in this area.

I recognize that it is not likely that the Patent Office has a subject matter expert in this area, even the non-nuclear version, since it is not something that comes up often in any venue in any detail. Please keep in mind that the purpose of patents is to take us to where no one has gone before, not just reiterate the past. This is what I want to do with my patent application, and I think that I am one of the few people who can do this credibly.

I hope that this short tutorial is of use to you in understanding the utility of my patent application. Comments on your other concerns are attached, as well as revised version of my original application that addresses editorial and word usage issues.

**OTHER CONCERNS raised in the examiner's Office Action Summary:
(In order of appearance)**

3. (a) Title of the Invention: I have read the referenced requirements and counted the number of characters in the title (about 268). Thus, I assume you are suggesting that the words to describe this patent application can fit in seven or less words. I might use "Automated method to communicate whistleblower concerns ~~anonymously~~", leaving out mention of "safety culture" and "circumventing middle management filters."

effectively

3. (b) Cross References to Related Applications: The previous patent application (Carlson, et al.) identified by the Examiner is added and dismissed as not dealing with the subject matter of the current invention.

3. (k) The abstract of the disclosure has been reduced to less than 150 words, as follows:

This invention is a method for allowing each individual in an organization to report his or her issues and concerns to senior managers, to regulatory bodies, and/or to the public with minimal or no changes or filtering. Such information may include routine and non-routine information falling within the knowledge or expertise of the individual, such as work planned and any related obstacles to that work. This invention provides a method to bypass potential filters within middle management, provides peer validation and an archival record, and motivates individuals to increase their forthrightness. The concerns information may be collected, aggregated, integrated, stored, and analyzed. This invention provides a means for workers and managers to communicate effectively with senior managers without mid-level managers modifying or delaying those communications and provides for concurrent peer-review validation of issues and concerns, avoiding "whistleblower" status for the originator.

4., 5. Noted and appreciated.

6. The period has been replaced with a comma.

7., 8., and 9: 35 U.S.C. § 101 issues as to the alternatives in methods and systems have been corrected.

10. The claims have been clarified to point out what is claimed as the subject matter of this invention.

11. Indefinite language has been removed to better define the scope of the claims.
12. The claims have been revised to include definite steps.
13. Claim 1 has been altered to be more definite and precise. The use of the beneficial new utility in this invention applies to all workers and managers who choose to use it, up to the most senior single person to whom someone of lower authority reports. Obviously, the most senior or most powerful person in an organization can not logically be a whistleblower who would need to use the beneficial aspects of this invention. It is likely that the examiner is confusing "issue" with "incident" in noting the concern for when the issue occurred. An issue is ongoing in many instances, where an incident generally occurs at a specific place and time, although an issue can encompass an associated incident or multiple incidents as part of the issue of concern to the originator of the communications enabled under this invention. A "timely submittal" can be at any time that the originator recognizes the implications of an issue and chooses to apply this invention so as to make the submittal timely, as compared with a submittal that does not use this invention and is required to take a path wherein it may or may not reach the person responsible due to a cumbersome or untimely process, or be rejected (the communication terminated) by a middle manager who may not understand the concern. The current invention is useful in convincing the middle managers of the validity of the concern due to its peer validation, but also due to the fact that the peer validated concern has already been sent to his or her senior managers, including the most senior person in the organization. The extension of the current invention beyond the immediate organization to other organizations parallels current practice to communicate concerns to different or similar organizations that can benefit from them either directly (i.e., organizations that have the same concern or concerns as those raised within other organizations using the current invention) or indirectly (i.e., organizations that monitor the numbers of concerns raised using the current invention).

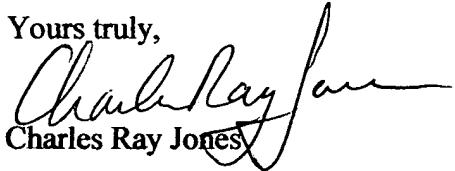
14. Claim 2 has been clarified. The use of terminology such as "routine computer software means" is only meant to elicit the use of any computer software having the capability to meet the needs of the method described.

15. Claim 3 has been clarified.

(Second and third) 11 and (second) 12. As already explained above, Carlson deals only with "incident reports" and not "safety culture" or the significant concerns of the individuals in an organization. Indeed, Carlson's methods stops the concerns of an individual by referring to incidents rather than to concerns. Systems to systematically deal with corrective actions such as reflected in Carlson have been in place at nuclear power plants for many years, yet emergent concerns raised by individuals are still frustrated and blocked from timely consideration, else we would not have had the incident at the Davis-Besse Nuclear Plant in which the reactor was started up over the objections of a responsible engineer in charge of an important corrective action, unknown

to the senior managers and to the Nuclear Regulatory Commission. Carlson's database in his system is searchable rather than private and anonymous. Access to information in the current invention is controlled in a manner that emphasizes protecting the concern originator. Carlson provides no "peer review" since nothing requires or suggests that any peers would be involved in an incident or in reporting on an incident. For example, a welder might report that a problem exists in a certain weld as evidenced in a radiograph inspection. In Carlson's invention, this would be the subject of an incident report submitted to Carlson's system and reported throughout the organization. The incident report might be disposed of and cancelled by a manager as being insignificant in terms of starting up the plant and operating with the defective weld. If the welder who submitted the "incident report" objects, his only path to relief is outside Carlson's system. Moreover, if he takes such a path, he becomes a "whistleblower" and is subject to retaliation. Under the current invention, the same welder could raise the same concern as reflected in the incident report and do so (1) anonymously and (2) with an indication of peer support as expressed by the other welders and radiography workers in the organization, whose inputs to the concern language would also remain anonymous, if appropriate. Thus, the focus remains on the concern and not on the people raising the concern. The examiner is correct in stating that there is no whistleblower problem if everyone involved in an incident is identified as supporting the Carlson incident report language and recommendations, but that is not relevant to the utility of the current invention. Again, the examiner demonstrates a lack of understanding of the nature of safety culture issues and how they impact an organization's ability to respond to individual concerns in that the examiner infers a particular result in this regard on behalf of Carlson something that Carlson did not claim and could not claim. It is also this language volunteered by the examiner that caused me to delay responding to this Office Action Summary, thinking that Carlson had specifically demonstrated as well as claimed a safety culture benefit as well as a peer review supporting process. Neither of these occurs in Carlson.

Yours truly,


Charles Ray Jones